DELAWARE SCHOOL PHYSICAL EXAMINATION FORM

To be completed by licensed medical physician, nurse practitioner or physician's assistant.

Name:_____ **Sex:**_____ **DOB:**_____

Date:_____ **Examiner:**_____

PLEASE CHECK IF CHILD HAS HAD DIFFICULTY WITH ANY OF THE FOLLOWING. GIVE DATES AND ADDITIONAL INFORMATION UNDER COMMENTS.

[ ] ADD/ADHD	**[ ] Body Piercing/Tattoo**	**[ ] Emotional**	**[ ] Physical Disability**
[ ] Allergies	**[ ] Bone/Spine**	**[ ] Hearing**	**[ ] Seizures**
[ ] Asthma	**[ ] Bowel/Bladder**	**[ ] Heart**	**[ ] Speech**
[ ] Behavior	**[ ] Chicken Pox**	**[ ] Infections**	**[ ] Surgery**
[ ] Bleeding	**[ ] Diabetes**	**[ ] Kidney**	**[ ] Vision**

[ ] OTHER _____

Comments:_____

_____

Height:_____ **Weight:**_____ **BP:**_____ **Pulse:**_____

Vision: **Right**_____ **Left**_____

Hearing: **Right**_____ **Left**_____

Lead Screening: **Date Completed**_____ **Results**_____

Hematocrit/Hemoglobin: **Date Completed**_____ **Results**_____

PPD (Mantoux): Date Placed_____ **Date Read**_____ **Results (in mm)**_____
or
TB Risk Assessment: Date Completed_____ **Results**_____

3. Immunizations – *Shaded Vaccines Required*

DTP/Hib 1 / /	**DTP/Hib 2** / /	**DTP/Hib 3** / /	**DTP/ Hib 4** / /	**DTaP/Hib 4** / /
DTP/DTaP 1 / /	**DTP/DTaP 2** / /	**DTP/DTaP 3** / /	**DTP/DTaP 4** / /	**DTP/DTaP 5** / /
DT/Td 1 / /	**DT/Td 2** / /	**DT/Td 3** / /	**DT/Td 4** / /	**DT/Td 5** / /
OPV/IPV 1 / /	**OPV/IPV 2** / /	**OPV/IPV 3** / /	**OPV/IPV 4** / /	**OPV/IPV 5** / /
MMR 1 / /	**MMR 2** / /	**HepB 1** / /	**HepB 2** / /	**HepB 3** / /
Hib 1 / /	**Hib 2** / /	**Hib 3** / /	**Hib 4** / /	
Hep B 1 (2 dose Version Only) / /	**Hep B 2 (2 dose Version Only)** / /	**Hep B/Hib 1** / /	**Hep B/Hib 2** / /	**Hep B/Hib 3** / /
Varicella 1 / /	**Varicella 2** / /	**Lyme Vax 1** / /	**Lyme Vax 2** / /	**Lyme Vax 3** / /
Pneumococcal Conjugate 1 / /	**Pneumococcal Conjugate 2** / /	**Pneumococcal Conjugate 3** / /	**Pneumococcal Conjugate 4** / /	
Pneumococcal Polysaccharide1 / /	**Pneumococcal Polysaccharide 2** / /	**Hep A 1** / /	**Hep A 2** / /	
Influenza 1 / /	**Influenza 2** / /	**Other:** / /	Other: / /	

CHILD'S NAME_____

PHYSICAL EXAMINATION	Check (✓) NORMAL	ABNORMAL	COMMENTS
General Appearance			
Head/Scalp			
Eyes			
Ears			
Nose/Throat			
Mouth/Teeth/Gums			
Heart			
Chest/Lungs			
Skin			
Abdomen/Hernia			
Genitalia			
Neurological			
Developmental			
Musculoskeletal			
Nutrition			

Health Concerns or Special Needs Identified:_____

_____

_____

FOR CHRONIC CONDITIONS:
Please attach care plan, protocols, and/or emergency care plan.
Children with life-threatening conditions need an emergency care plan in place.

Recommendations or Referrals:_____

_____

_____

Examiner's Signature:_____ **Date:**_____

Printed Name_____ **Phone Number:**_____

Address:_____